



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:
Diagnostic Imaging Institute, Inc. P.O. Box 743125 Dallas, TX 75374	M4-07-2975-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
Royal Indemnity Co. Rep. Box #: 11	Employer Name:
	Insurance Carrier:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "DDI, Inc. performed a Functional Capacity Evaluation on your claimant at the request or with the approval of the Texas Workers' Compensation Commission. In a Designated Doctor (DD) setting, the physician can order any diagnostic test necessary to validate his or her findings in order to address the Commission's concerns and questions..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$447.00
3. CMS 1500(s)
4. EOB(s)

Sent

SEP 11 2007

TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a response

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute	Ordered Amount
02/27/06	97750-FC (\$29.85 x 125% x 12 Units)	I -- 4	\$447.00	\$447.00
Total Due:				\$447.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines

1. These services were denied by the Respondent with reason code "W-I— Workers Compensation State Fee Schedule Adjustment" and "D – Duplicate Charge."
2. Per Rule 130.6(g) the designated doctor may perform additional testing or refer the injured employee to other health care providers when deemed necessary to assess an impairment rating. Furthermore, the Respondent has not submitted any information to support the denial of "Duplicate Charge." Therefore, per Rule 134.202© reimbursement in the amount of \$477.00 is recommended.

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